

# JUVENILE JUSTICE DISCHARGE PROGRESS NOTE

Date:	Telephone Contact: <input type="checkbox"/> Y <input type="checkbox"/> N	Rendering Provider Face-to-Face/Other Time* (Hrs:Mins): _____
Procedure Code:	Other Staff Initials:	Total Time* (Hrs/Mins): _____
* All travel and documentation time must be recorded as "Other" or "Total Time"		Other Staff Initials: _____
		Total Time* (Hrs/Mins): _____

MHS Activity Type	<input type="checkbox"/> Assessment	<input type="checkbox"/> Ind Tx	<input type="checkbox"/> Ind Reh	<input type="checkbox"/> Col	<input type="checkbox"/> PsyT	<input type="checkbox"/> Team Conf/CaseCon		Other Activity Type	<input type="checkbox"/> Cris Int	<input type="checkbox"/> TCM
	<input type="checkbox"/> Other:	<input type="checkbox"/> GrpTx	<input type="checkbox"/> GrpReh	# of Clients Represented: _____						

Juvenile Justice Discharge Information was completed and given to the client for purposes of referral and follow-up with mental health treatment upon release from Juvenile Justice See form dated:

**Additional Discharge Information**

Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Presenting Information and target symptoms (if not on the Discharge Information form):

Response to Services and Disposition:

**Discharge Diagnosis:**

Axis I	<input type="checkbox"/> Prin	<input type="checkbox"/> Sec	Code		Nomenclature
		<input type="checkbox"/> Sec	Code		Nomenclature
			Code		Nomenclature
			Code		Nomenclature
Axis II	<input type="checkbox"/> Prin	<input type="checkbox"/> Sec	Code		Nomenclature
		<input type="checkbox"/> Sec	Code		Nomenclature
Axis III	_____			Code	
	_____			Code	
	_____			Code	

Axis IV Psychological and Environmental Problems which may affect diagnosis, treatment, or prognosis (Check all that apply)

- 1.  Primary support group
- 2.  Social environment
- 3.  Educational
- 4.  Occupational
- 5.  Housing
- 6.  Economics
- 7.  Access to health care
- 8.  Interaction with legal system
- 9.  Other psychosocial/environmental
- 10.  Inadequate information

Axis V Discharge GAF: \_\_\_\_\_ Prognosis: \_\_\_\_\_

**Additional Information:**

Continued (Sign & complete claim information on last page of note.)

Signature & Discipline	Date	Co-signature & Discipline (If Required)	Date
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<p>This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.</p>	<table style="width: 100%;"> <tr> <td style="width: 50%;">Name:</td> <td style="width: 50%;">IS#:</td> </tr> <tr> <td>Agency:</td> <td>Provider #:</td> </tr> <tr> <td colspan="2" style="text-align: center;">Los Angeles County – Department of Mental Health</td> </tr> </table>	Name:	IS#:	Agency:	Provider #:	Los Angeles County – Department of Mental Health	
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